DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 98-011

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

DEC 31 98

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 1, 1998

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 1999 $ 0
b. FFY 2000 $ 60,950

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D(4)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Nursing Facility Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bruce M. Bullen (per BS)

13. TYPED NAME:
Bruce M. Bullen

14. TITLE:
Commissioner

15. DATE SUBMITTED:
December 30, 1998

16. RETURN TO:
Bridget Landers
Coordinator for State Plan
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 31, 1998

18. DATE APPROVED:
May 7, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
December 1, 1998

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Ronald F. Preston

22. TITLE:
ARA, DMSO, Boston Region

23. REMARKS:

OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MASSACHUSETTS MEDICAL ASSISTANCE PROGRAM

Methods Used to Determine Rates of Payment for Nursing Facilities

I. GENERAL DESCRIPTION OF PAYMENT METHODOLOGY

A. **Overview:** Nursing facility payments for services rendered to publicly-assisted residents are governed by the Division of Health Care Finance and Policy (DHCFP) regulation, 114.2 CMR 6.00: **Standard Payments to Nursing Facilities**, the regulation which implements this methodology. The following sections in this attachment describe the methods and standards used to establish payment rates for nursing facilities effective February 1, 1998.

B. **Chief Components**: The payment method, described below, begins a shift away from historical facility specific cost-based reimbursement to standard payments for nursing facility services. It establishes standard payment rates for Nursing and Other Operating Costs, as well as payment rates for Capital. For rate year 1998 there are several transition adjustments to ease the transition to standard payments. In addition, a mechanism for voluntary participation in an Ancillary Services Pilot program is established, to be conducted by the Division of Medical Assistance.

II. COST REPORTING REQUIREMENTS AND COST FINDING

A. **Required Reports:** Each provider of long-term care facility services under the State Plan must complete an annual report (the "Annual Report") containing cost information for the cost reporting year on the basis of generally accepted accounting principles and the accrual method of accounting. There are three (3) reports required: a) Nursing Facility Cost Report; b) Realty Company Cost Report; and Management Company Cost Report. All cost reporting must meet the requirements set forth in **Appendix A** (*114.2 CMR 6.06 (1)*). There are special cost reporting requirements for Hospital Based Nursing Facilities and facilities which operate other programs such as Adult Day Health, Assisted Living or Outpatient Services. These requirements are outlined in **Appendix A** (*114.2 CMR 6.06 (3)*).

B. **Filing Dates: Reports:** Except as provided below, Providers must file the required Cost Reports for the calendar year by 5:00 PM of April first of the following calendar year. If April 1, falls on a weekend or holiday, the Reports are due by 5:00 PM of the following business day.

1. *Change of Ownership*. Where there has been a change of ownership, the transferor shall file the Report(s) within sixty (60) days after the transfer of ownership. Where the transferor fails to submit the Report(s) , the Division of Health Care Finance and Policy may request the Division of Medial Assistance to withhold payment to the transferee until such reports are appropriately filed.

2. *New Facilities and Facilities with Major Additions*. For the first two calendar years of operation, New Facilities and Facilities with Major Additions shall file year-end Cost Reports within sixty (60) days after the close of the calendar year.

3. *Hospital-Based Nursing Facilities*. A Hospital-Based Nursing Facility is a separately licensed unit housed on the premises of a facility which is licensed for both hospital and long-term-term care services, where the long-term-term care beds were converted from licensed hospital beds or otherwise acquired. Hospital-Based Nursing Facilities must file the Report(s) on a fiscal year basis

which is consistent with the filing of such facilities' hospital cost reports. The Report(s) is due no later than ninety (90) days after the close of the facility's fiscal year.

4. *Termination of Provider Contract.* Whenever a provider contract between the provider and the Division of Medical Assistance is terminated, the provider shall file Reports covering the current reporting period or portion thereof covered by the contract and any other Reports required by the Division of Health Care Finance and Policy, within sixty (60) days of such termination. When the provider fails to file the required Reports in a timely fashion, the Division of Health Care Finance and Policy shall notify the provider of this failure by written notice sent registered mail, return receipt requested

5. *Appointment of Patient Protector Receiver.* If a receiver is appointed pursuant to court order under M.G.L. c. 111, s. 72N, the provider must file Reports for the current reporting period or portion thereof within sixty (60) days of the receiver's appointment.

C. **Filing Extensions:** The Division of Health Care Finance and Policy may grant an extension, up to forty-five (45) calendar days, for submission of the Report(s). A request for an extension must: (a) be submitted in writing to the Division of Health Care Finance and Policy by the provider and not by an agent or other representative; (b) show that exceptional circumstances exist precluding the provider from submitting the Report(s) in timely fashion; and (c) be submitted no later than 30 calendar days before the filing due date.

D. **Incomplete Submission:** The Division of Health Care Finance and Policy shall notify the provider within one hundred twenty (120) days of receipt of the Reports if it finds that the submission is incomplete and shall specify what additional information is required to complete the submission. The provider shall file the necessary information with the Division of Health Care Finance and Policy within twenty-five (25) days of the date of notification or by April 1 of the year the Report is filed, whichever is later. The Reports and all accompanying schedules is deemed to be filed with the Division of Health Care Finance and Policy as of the date the Division of Health Care Finance and Policy receives complete submission.

If the Division of Health Care Finance and Policy fails to notify the provider within the 120-day period, the submission is considered complete and the Report(s) and all accompanying schedules is deemed to be filed with the Division of Health Care Finance and Policy as of the date of receipt.

E. **Audits:** The Divisions of Health Care Finance and Policy and Medical Assistance may conduct desk or field audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any related party as requested, even if the Division of Health Care Finance and Policy has accepted such Provider Cost Reports.

F. **Penalties for Failure to File Timely:** A provider's rate for current services will be reduced by 5%, if the required Cost Reports are not filed in a timely manner. On receipt of such cost reports the Provider's rate will be restored effective on the date of report filing.

G. **General Cost Principles:** In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria:

1. The cost is ordinary, necessary and directly related to the care of publicly-aided patients;
2. The cost is for goods or services actually provided in the nursing facility
3. The cost must be reasonable; and,
4. The cost must actually be paid by the provider. Costs which are not considered related to the care of Medicaid patients include, but are not limited to: costs which are discharged in bankruptcy; costs which are forgiven; costs which are converted to a promissory note; and accruals of self-insured costs which are based on actuarial estimates.
5. A provider may not report any of the costs that are listed in **APPENDIX A** *(114.2 CMR 6.06 (4))* as related to Medicaid patient care.

III. METHODS AND STANDARDS USED TO DETERMINE PAYMENT RATES

A. **Prospective Per Diem Rates:** The prospective per diem payment rates for nursing facilities are derived from several components: Standard Payment Rates for Nursing and Other Operating, Capital Payments, 1998 Transition Payments, and a Total Payment Adjustment. Each of these components is described in detail in the following sections.

B. **Standard Payment Rates:** The following are the standard payment rates established for Nursing and Other Operating Costs:

Case Mix Category	Nursing Standard Payment	Other Operating Standard Payment
1	$ 15.83	$ 45.33
2	$ 15.83	$ 45.33
3	$ 15.83	$ 45.33
4	$ 49.25	$ 45.33
5	$ 49.25	$ 45.33
6	$ 49.25	$ 45.33
7	$ 49.25	$ 45.33
8	$ 77.38	$ 45.33
9	$ 77.38	$ 45.33
10	$ 94.18	$ 45.33

1. ***Determination of Nursing Standard Payment Rates:*** The base year used to develop the Nursing Standard Payment Rates is 1996. Nursing costs reported in 1996 in the following categories are included in the calculation: Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, Director of Nurses and Nursing Workers' Compensation, Payroll Tax, and Fringe Benefits, including Pension Expense. The payment rates are derived from the product of the industry 1996 median nursing costs times the 1996 industry median management minutes for each of four (4) payment groups. **Appendix A** (114.2 CMR 6.04(1)(a)(3)). The base year amounts for each group are updated to rate year 1998 by a cost adjustment factor of 5.12%. This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as nation and regional indices supplied by DRI.

2. ***Determination of Other Operating Standard Payment Rates:*** The base year used to develop the Other Operating Standard Payment Rates is 1996. Other operating costs reported in 1996 in the following categories are included in the calculation: variable, administrative & general, and motor vehicle costs. Administrative & general costs are subject to a ceiling of $ 10.51 before combining with other cost components. The Other Operating standard is set equal to the 1996 industry average of these cost amounts, subject to an audit findings adjustment. The audit findings adjustment reduced the Other Operating

standard payment rate by 1.8% to account for prior year audit findings which identified that certain operating costs related to indirect ancillary services were inaccurately reported on the prior year cost reports. The 1996 amount is updated to rate year 1998 by a cost adjustment factor of 5.12%. This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as nation and regional indices supplied by DRI.

C. **Capital Payments:** The Capital Payment for all facilities, except for those described below under **Capital Payment Exceptions,** equals either: (a) the sum of the facility's 1997 certified capital payment per diem; or, (b) the greater of $ 17.29 or 90% of the 1997 capital payment per diem. The 1998 capital payment will be computed under (a) above where a facility's 1997 certified capital payment per diem was equal to or less than $ 17.29 per diem. The 1998 capital payment will be computed under (b) above where a facility's 1997 certified capital payment per diem was greater than $ 17.29 per diem. The 1997 certified capital payment per diem is the Allowable Fixed Costs and Equity per diem that was certified by the Division of Health Care Finance and Policy for the period ending December 31, 1997. **Appendix A** (114.2 CMR 6.05(2)(a)-(e)).

1. ***Capital Payment Exceptions***: For facilities that meet the criteria below the capital payment for rate year 1998 will be $ 17.29:

   a) Facilities which open or become operational in 1998 pursuant to a Determination of Need Approved after March 7, 1996;
   b) Replacement facilities which open in 1998 pursuant to a Determination of Need approved after March 7, 1996;
   c) Facilities which open in 1998 in Urban Underbedded areas that are exempt from the Determination of Need process;
   d) New beds that become licensed in 1998 pursuant to a Determination of Need approved after March 7, 1996;
   e) New beds which represent 12 bed expansion project which are not associated with an approved Determination of Need project;
   f) Hospital-Based Nursing Facilities; and
   g) Private Nursing Facilities that sign a Provider Agreement with the Division of Medical Assistance in 1998.

2. Facilities with licensed beds that were out of service in 1996 which re-opened in 1998 will receive a Capital Payment of the lower of $ 17.29 per day or the facility's most recent billing rates for Fixed Costs and Equity or Use and Occupancy.

3. For Facilities with beds licensed prior to 1998 that add new beds or renovate in 1998, the Division of Health Care Finance and Policy will calculate a blended Capital Payment based on the rates calculated under the methods described above and outlined in **Appendix A.** (114.2 CMR 6.03(2)(b)- (d)).

D. **1998 Transition Payments**

1. ***Nursing Payment Rates*:** Nursing facilities receive four (4) **Nursing Payment Rates** which are equal to the sum of the **Nursing Standard Payment Rates** described in **Section III.B.1.** herein, plus a transition payment adjustment. The transition payment adjustment equals the difference between the **Nursing Standard Payment Rates** and each facility's reasonable and allowable nursing cost per diem amounts. Each facility's reasonable and allowable nursing cost per diem amounts are derived from its reported 1996 nursing costs and 1996 management minutes, subject to a cost per management minute ceiling of the industry median. plus 10%, and increased by the cost adjustment factor of 5.12%. See, **APPENDIX A** (114.2 CMR 6.04 (1)).

2. ***Other Operating Payment Rates:*** Nursing facilities receive Other Operating Payments which are equal the **Other Operating Standard Payment Rate** described in **Section III.B.1.** herein, plus a transition payment adjustment. The transition payment adjustment equals the difference between the **Other Operating Standard Payment Rate** and a blended per diem amount comprised of: (a) 33% of the **Other Operating Standard Payment Rate;** plus (b) 66.7% of the facility's reasonable and allowable other operating costs. Each facility's reasonable and allowable other operating costs are derived from its reported 1996 other operating costs, subject to a ceiling on administrative and general costs of $10.51 per diem and an overall ceiling of $50.61 (industry median plus 6%), and increased by the cost adjustment factor of 5.12%. See, **APPENDIX A** (114.2 CMR 6.04 (2)).

E. **Total Payment Adjustment:** A total payment adjustment is applied to the payment rates. The total payment adjustment is the percentage difference between a facility's weighted 1997 payment rate and the 1998 weighted payment rate computed using the methods described herein under: Standard Payment Rates for Nursing and Other Operating, Capital Payments and 1998 Transition Payments. Each rate was weighted according to its casemix proportion, using case mix data for the third quarter of 1997. If a facility's 1998 weighted payment rates is less than its 1997 weighted payment rate, the facility's 1998 weighted rates equal the 1997 rates. If the facility's 1998 weighted payment rate exceeds its 1997 weighted rate by more than 9%, the increase in its weighted rate was limited to 9%. See, **APPENDIX A** *(130 CMR 6.04 (4)).*

F. **Ancillary Costs**: Commencing in 1998, a provider may apply to the Division of Medical Assistance to participate in a alternative Ancillary Pilot Program for payment of Ancillary services. Participation is voluntary, subject to approval by the Division of Medical Assistance. Appendix E., contains the payment methodology for incentive payments that may be made to the providers who participate in the voluntary Ancillary Pilot Project, commencing December 1, 1998.

G. **Rate Limitations**

1. ***Medicare Upper Limit of Payment:*** No weighted average prospective rate of payment established under 114.2 CMR 600 et seq. (**Appendix A**) shall exceed the amount that can be reasonably estimated to be paid for these services under Medicare principles of reimbursement. An adjustment will be made only to the extent the costs are reasonable and attributable to the circumstances specified under the Medicare principles and separately identified and verified by the provider.

MAY 07 2001

OFFICIAL

2. ***Private Rate Limitation:*** No prospective rate of payment established under 114.2 CMR 6.00 (see **APPENDIX A**)shall exceed the rate charged by the provider to private patients for the same or similar services and accommodations. The limitation shall not apply to that portion of prospective rates established for Patient Protector Receivers appointed pursuant to M.G.L. c. 111, s.72N et seq. **(Appendix C)**.

3. ***Methodology:*** The Division of Health Care Finance and Policy in calculating the private rate limitation shall: Determine the weighted average Publicly-Aided patient rate for the Base Year and compare it to the average private rate for the same period, as reported in the cost report for the Base Year. If a facility's weighted average prospective rate for its Publicly-Aided Patients is greater than the average rate charged by the provider to private patients, the provider may produce justification for such lower rate for private patients before the limitation is applied. Such justification shall include quarterly Management Minute Questionnaires for all private patients. If the provider can classify the private patients into one of the ten case-mix categories, the rate limitation will be the prospective rate for Publicly-Aided Patients as established by the Division of Health Care Finance and Policy for that case-mix category rather than the weighted average rate for all Publicly-Aided patients.

4. ***Failure to Meet the Rate Limitation:*** When a long-term care provider fails to satisfy the requirement for rates charged to private patients, the Division of Health Care Finance and Policy shall multiply the difference between the weighted average rate for Publicly-Aided Patients and the average rate charged to private patients by the number of patient days for those discounted private patients to determine the aggregate difference.

H. **Rate Year Adjustments**: Adjustments to rates will occur in the following circumstances:

1. **Retroactive Adjustments:** The Division of Health Care Finance and Policy will retroactively adjust rates in the following situations: Facilities which did not file a 1996 Cost Report, Facilities which opened in 1997, Amended 1997 Rates, Mechanical Errors, and Errors in the Cost Reports. For a detailed description of each situation, please refer to **APPENDIX A** (114.CMR 6.05 (1)).

2. **Capital for Newly-licensed Beds, and Renovated Facilities:** The Division of Health Care Finance and Policy will re-calculate Capital Payments for new beds that become licensed in 1998 and for facilities which are renovated pursuant to an approved Determination of Need. Capital payments for these facilities will be determined pursuant to **Appendix A** (114.2 CMR 6.05(2)).

I. **Notification Process.** Any facility which opens in 1988 or adds new beds or adds substantial renovations in 1988 is required to notify the Division of Health Care Finance and Policy for purposes of establishment of nursing facility payment rates. These requirements are detailed in **Appendix A** (114.2 CMR 6.05(3)).

I. SPECIAL CONDITIONS

A. **Rate for Innovative and Special Programs:** The Division of Medical Assistance may contract for special and/or innovative programs to meet special needs of certain patients which are not ordinarily met by existing services in nursing facilities. Currently, these programs include programs for patients with traumatic brain injury, mental illness and medical illness (MIMI's), technologic dependency, as well as a program for nursing facilities that have a substantial concentration of patients of the highest acuity level (i.e. Management Minute Category T).

A provider who seeks to participate in an innovative and special program must contract with the Division of Medical Assistance to provide special care and services to distinct categories of patients designated by the Division of Medical Assistance. This is usually done through a Request for Proposals by the Division of Medical Assistance for special or innovative programs to address special needs of certain patients which are not ordinarily met by existing services in nursing facilities. Reimbursement under the innovative and special programs may be calculated based on the added allowable actual costs and expenses which must be incurred (as determined by the Division of Medical Assistance) by a provider in connection with that program. However, it still must be consistent with the payment methodology established for long-term care facilities. The provider must verify that such items or services are furnished because of the special needs of the patients treated as contemplated in the contract with the Medical Assistance Program, and that such items or services are necessary in the efficient delivery of necessary health care. These costs will be added as an increment to the facility's rate in establishing a rate for an innovative and special program. In the event that the special program is located within a special unit, the remaining costs of the unit are to be integrated into the cost report for the entire facility.

A facility that has recently converted from a facility providing non-acute hospital services to a facility providing nursing facility services may be reimbursed as a special program. In order to be considered as a special program, such a facility must agree to provide, or arrange and pay for, all Medicaid covered services, except hospital services, to all Medicaid recipients that are residents of the facility. The reimbursement to such facilities is a per diem rate which is the facility's regular case mix rates with an add-on which is based on the reasonable costs of providing the goods and services beyond those required to be provided by nursing facilities.

A provider whose resident population primarily and consistently consists of high-acuity high-nursing need residents such that the aggregate need of the entire population requires a staffing level significantly greater than a typical nursing facility may be reimbursed as a special program, in which case the increment added to the facility's rate may apply to all residents of the facility and will be calculated based on allowable costs associated with the higher care needs of the patients. In order to be eligible for reimbursement under this paragraph, a nursing facility must meet each of the following criteria:

1. at least ninety percent (90%) of its residents must have Management Minute ("MM") scores that fall in either MM category 9 or 10 and at least seventy-five percent (75%) of its residents must have MM scores that fall in MM category 10; or (ii) the facility must be a former acute hospital that has undergone conversion to a nursing facility under the auspices of the Massachusetts Acute Hospital Conversion Board; and,

2. the mean MM score for all residents of the facility in MM category 10 must be at least fifteen percent (15%) higher than the minimum score needed to quality for MM category 10; and,

3. the facility must be a geriatric nursing facility.

B. **Pediatric Nursing Facilities:** Payments will be determined using 1996 reported costs for Nursing and Other Operating Costs, excluding Administration and General Costs. Administration and General Costs will be subject to a cap of $ 10.51. Pediatric nursing facilities may apply to the Division of Health Care finance and Policy for the costs of programs to address the special needs of pediatric nursing facility residents over the age of 22 which are not ordinarily met by existing services in pediatric nursing facilities. The

Division of Health Care Finance and Policy will calculate an add-on to include the reasonable costs for specialized health care services to this patient population.

C. **New Facilities:** New Facilities that open in 1998 will be paid at the Standard Payment Rates for Nursing and Other Operating Costs. Capital payments for these facilities will be determined pursuant to **Appendix A** (114.2 CMR 6.05(2)).

D. **Beds Out of Service:** Facilities with licensed beds that were out of service in 1996 which re-open in 1998 will receive the lower of the Standard Payment rates or the most recent prior billing rates inflated to 1997 for Nursing and Other Operating Costs.

E. **Legislative Mandate for Rate Relief:** A nursing home (i) with rate of public utilization, consisting of Medicare, Medicaid and Commission for the Blind patients, of ninety percent or more, (ii) located in the service area of a federally designated sole community hospital, and (iii) with more than 10% of its variable costs and nursing costs disallowed by the Division of Health Care Finance and Policy pursuant to 114.2 CMR 5.00 or any successor regulation, shall have all of its variable costs and nursing costs recognized by the Division of Health Care Finance and Policy and its Medicaid rate adjusted accordingly. The Division of Health Care Finance and Policy shall adjust the prospective rates for any such nursing home that meet the aforementioned criteria for the rates that were effective January 1, 1994 and for each succeeding rate year that such nursing homes comply with aforementioned criteria. The amount of variable costs and nursing costs recognized as allowable by the Division of Health Care Finance and Policy for any rate for a nursing home is limited to an amount that will not increase costs to the Medical Assistance program in an amount greater that three hundred thousand dollars. Not withstanding anything to the contrary contained in this paragraph, in no case shall the provisions of this paragraph apply to any services rendered prior to February 1. 1998.

Any nursing facility that meets either the standards set forth in **(a) or (b)** below shall have its total acquisition costs allowed as the allowable basis of fixed assets, notwithstanding any limits on the same that appear elsewhere in this State Plan, when the Division of Medical Assistance calculates the facility's payment rates. This provision shall only apply to services rendered on or after February 1, 1998.

(a)

1. the owner purchased the nursing home on or after January 1, 1987;

2. the owner has received a determination letter from the Internal Revenue Service that it is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986;

3. the owner (i) owns a nonprofit hospital (the "Hospital") located within the Commonwealth of Massachusetts which is licensed by the Department of Public Health or (ii) is a nonprofit organization affiliated with a nonprofit hospital which is organized and operated for the benefit of, to perform one or more functions of, or to carry out one or more of the purposes of the nonprofit hospital it is affiliated with, including operation of freestanding nursing homes licensed by the Department of Public Health;

4. the owner's patient population is, on average, not less than eighty-five percent (85%) Medicaid recipients;

5. the Hospital has, on average, not less than eighty percent (80%) occupancy of medical or surgical beds;

6. when the owner purchased the nursing facility (i) the change of ownership did not occur between a person or organization which is associated or affiliated with or has control of or is controlled by the owner or is related to the owner or any director, trustee, partner, shareholder or administrator of the owner by common ownership or control or in a manner specified in section 267(b) and (c) of the Internal Revenue Code of 1986; (ii) the change of ownership was made for reasonable consideration; (iii) the change in ownership was a bona fide transfer of all powers and indicia of ownership and (iv) the change of ownership manifested an intent to sell the assets of the facility rather than implement a method of financing, or refinancing:

or

(b)

1. the owner acquired the nursing facility from an acute care hospital to operate the facility pursuant to relief granted to the acute care hospital by the acute care hospital conversion board pursuant to M.G.L. c.6A, s.101;

2. the acute care hospital conversion board approved the owner's acquisition costs of the facility; and,

3. on average, no less than eight-five percent (85%) of the nursing facility's patient population are Medicaid recipients.

Notwithstanding anything to the contrary contained in this State Plan, any nursing home that is owned by the Martha's Vineyard Hospital Foundation during the time that said Foundation also administers a federally designated sole community provider hospital shall have allowed all of its extra variable and fixed costs that reasonably result from such nursing home being located in a geographically isolated area.

Notwithstanding anything to the contrary contained in this State Plan, any nursing home that has over 75% of its residents having a primary diagnosis of multiple sclerosis shall have all of its nursing costs recognized as an allowable cost.

F. **Reimbursement of a Receiver Appointed Under M.G.L. c.111 s.72N et seq. (see Appendix C);** The prospective rates of a facility will be increased by an appropriate per diem amount to provide reasonable compensation to a receiver.

G. **Review and Approval of Rates and Rate Methodology By The Division of Medical Assistance:** Pursuant to M.G.L. c 118E, s.13 (see **Appendix D**) the Division of Medical Assistance shall review and approve or disapprove, any change in rates or in rate methodology proposed by the Division of Health Care Finance and Policy. The Division of Medical Assistance shall review such proposed rate changes for consistency with state policy and federal requirements, and with the available funding authorized in the final budget for each fiscal year prior to certification of such rates by the Division of Health Care Finance and Policy; provided that, the Division of Medical Assistance shall not disapprove a rate increase solely based on the availability of funding if the Federal Health Care Finance Administration provides written documentation that federal reimbursement would be denied as a result of said disapproval and said documentation is submitted to the Massachusetts House and Senate Committees on Ways and Means. The Division of Medical Assistance shall, whenever it disapproves a rate increase, submit the reasons for disapproval to the Division of Health Care Finance and Policy together with such recommendations for changes. Such disapproval and recommendations for changes, if any, is submitted to the Division of Health Care Finance and Policy after the Division of Medical Assistance is notified that the Division of Health Care Finance and Policy

intends to propose a rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing held by the Division of Health Care Finance and Policy regarding such rate change; provided that no rates shall take effect without the approval of the Division of Medical Assistance. The Division of Health Care Finance and Policy and the Division of Medical Assistance shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the Massachusetts House and Senate Committees on Ways and Means.

The Division of Health Care Finance and Policy shall supply the Division of Medical Assistance with all statistical information necessary to carry out the Division's review responsibilities under this Section. Not withstanding the foregoing, said Division of Medical Assistance shall not review, approve, or disapprove any such rate set pursuant to Chapter twenty-three of the Massachusetts Acts of Nineteen Hundred and eighty-eight.

If projected payments from rates necessary to conform to applicable requirements of title XIX are estimated by the Division of Medical Assistance to exceed the amount of funding appropriated for such purpose in the budget for such fiscal year, the Division of Medical Assistance and the Division of Health Care Finance and Policy shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the State Plan developed by the Division of Medical Assistance under Title XIX of the Federal Social Security Act.

H. **Appeals:** A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after the Division of Health Care Finance and Policy files the rate with the State Secretary. The Division of Health Care Finance and Policy may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal.